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Speaking whose language? Metaphors in clinical practice

CLINICAL REFLECTION

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SUMMARY

People who seek advice about their mental health or help with their psychological distress may use complex metaphors to communicate. It can be helpful for psychiatrists to be attuned to the details of people's language. In this brief article, we offer two vignettes to illustrate how metaphors can open up understanding in psychiatric practice.

KEYWORDS

Psychotherapy; narrative medicine; clinical encounter; metaphor; adult attachment.

In his classic text *Persuasion and Healing*, Jerome Frank argues that metaphor is essential as a rhetorical or 'persuasive' aspect of any psychotherapeutic process that aims to help people seeking to change their minds. Metaphor may therefore be important for psychiatrists as a way of supporting the psychotherapeutic process within clinical encounters. Sometimes, the lines of communication are straightforward, and we think here of patients who 'give a good history' or allow us to 'take' their history. Such individuals may make use of metaphors or similes – often clear ones – that convey colour or deliver precision to their experiences: 'My headache started like a thunderclap'; 'Since I lost my job, I've felt so tired, I'm walking through treacle'.

In other clinical encounters, however, it can be harder to interpret the patient's communications and the metaphors they use. We are thinking here of consultations that may leave clinicians feelings confused or perhaps frustrated at a patient who is, seemingly, meandering or going off at tangents. As one doctor remarked during a case discussion, 'Why was the patient talking about football when I needed to know the history of his depression?'

In such situations, as clinicians, we may feel an impulse to become more directive towards the patient in an effort to understand their presenting issues. We may tighten our focus, ask closed questions and pass over the content of the patient's 'off track' metaphors. Although this directive response may sometimes be effective (and indeed necessary), in our experience its impact is variable and it may sometimes serve to increase confusion rather than bring clarity.

In this article, we use fictional clinical vignettes to demonstrate how close attention to patients' metaphors may make a clinical encounter more fruitful. This may be especially important for metaphors that initially seem strange or irrelevant. Just as 'junk DNA' turns out to hold vital information, we suggest that nearly all that a patient says may tell us something about their problems, and a metaphor is no different. The meanings carried by a metaphor may not always be immediately clear, and often need some back-and-forth to make sense of, as we describe in the illustrative vignettes below.

Vignette 1: in which a man uses a metaphor to explain something about his mental state after a disaster

Mr Hearn killed his mother when he was mentally ill. He was then aged 23. Over the next 20 years, he remained chronically unwell and was a forensic patient in secure services for years. However, gradually his mental state improved and his team made a plan for him to move into less secure accommodation with access to the community. In preparation for this move, it was suggested that he might be offered some therapy to talk about his life to date. Mr Hearn was naturally cautious but was willing to give it a try. In the early sessions, he talked a great deal about the hospital and the life he had lived in it. When after several sessions, I raised the question of his offence and its impact on him, Mr Hearn looked blank and said somewhat tonelessly 'I've just got to pick up the pieces and move on'. He then changed the subject and I decided not to comment at that time. But the next week, Mr Hearn seemed unsure how to begin and was unusually quiet. When after a shortish silence I asked what was going on for him, he repeated, as he had done the previous week, 'I've just got to pick up the pieces and move on'.

I was aware of feeling rather blank and numb myself; and then I thought he might be telling me something about his own state of mind.

'You were in pieces?'

Mr Hearn sighed and said 'After she died, I was shattered… completely shattered'.

This disclosure allowed us to make a start on what his offence had done to his life and the lives of others; and enabled him to say much more about the

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offence and his relationships with his whole family, including his mother. He did return to the metaphor of 'picking up the pieces', usually when he was feeling distressed and inarticulate. Together, we came to think that the metaphor had become his way of showing others that he was feeling overwhelmed, both by the destructiveness of killing his mother and by the assault the act had made on his own mind. The wish to 'pick up the pieces' pointed to his sense that something remained in pieces that could not be put back together.

Vignette 2: in which a patient offers a comment that becomes the basis of a mutative metaphor

I first met Ms McLean in an out-patient mental health setting, where she had been referred by her general practitioner with long-standing depression. In her 60s, with long white hair tied back neatly, she appeared physically slight and had a direct, business-like manner. Our first meeting focussed on her background history and recent difficulties, which she described clearly and concisely. She did not have many ideas about what was depressing her: 'Perhaps it's just the way it is… I probably just need to keep busy'. We arranged to meet again 2 weeks later, and she thanked me for my time. I left that first meeting with the sense that Ms McLean was a straightforward patient and that I had done a good job.

At the start of the second meeting, Ms McLean spontaneously spoke about how, after our first appointment, she had found herself gazing at some cream cakes in a bakery window. She wanted one very much, but felt greedy and guilty about this. She stopped herself: 'Sorry, I'm going off topic. What else do you need to know?'

The invitation was to pass over the image and return to my own agenda, to more 'worthy' questions. The image stayed with me, however, and I decided to follow it.

'What about those cream cakes, behind the glass?' I asked.

Ms McLean paused, broke eye contact: 'Those cakes… I shouldn't have them. They're not for me'. She then returned briskly to her usual demeanour: 'This afternoon, I need to care for my sister – she's not well'.

It became apparent that Ms McLean filled her days caring for others to the point of exhausting herself, often stoically, slightly resentfully and without really questioning what she was doing and why. She described her days as full, but also somehow empty and unsatisfying. With further exploration, she spoke about growing up in a very busy household, with a sense that good care was just out of reach.

Over several meetings, the metaphor of 'cream cakes just out of reach' became a useful way of articulating an important dynamic for Ms McLean that resonated across her life so far: her sense that goodness in others and in the world was unavailable to her, as if behind glass. This left her with long-standing feelings of emptiness and a sense of unsatisfaction (and depression) relating to her own unmet needs. She seemed to locate her own needs in others, compulsively caring for other people while depriving herself of nourishment. Indeed, on reflection, I wondered whether in our first meeting, she had been looking after me: comfortable in her role as a 'good patient', making me feel like a good doctor, while leaving herself emotionally unfed.

We were able to use her metaphor to explore her anxieties about asking for what she needed or allowing herself to take it. Is there always glass in the way? And who is putting it there now?

Some theoretical background to metaphors in clinical practice

The study of metaphor as part of human language is ancient. The word itself is derived from a Greek word meaning 'to carry across', which points directly to metaphor's role in social communication of meaning. Metaphor not only represents a speaker's psychological experience; it also presents that experience to an audience or a listener. When a speaker uses metaphor, it embodies their psychological experience in language (Kirmayer 2025), i.e. it reflects a person's phenomenal experience both physically and psychologically. Indeed, psychoanalytic literature argues for the importance of our early experiences in influencing later life patterns – and suggests that infants' mental life is initially grounded primarily in bodily sensations and relational experiences, with more abstract forms of reasoning developing gradually over time (Isaacs 1948; Montirosso 2020). From this perspective, when an adult uses metaphor to communicate, this may serve as a way to carry across important, non-verbal experiences and meanings that cannot easily be expressed in more literal forms of language.

Formal study of metaphor from a linguistic perspective starts in the 19th century with work by Vico and Nietzsche and continues in the 20th century with Wittgenstein and Lakoff & Johnson. From a linguistic perspective, metaphor is a basic cognitive structure as well as a device for communication in a cultural context. The human capacity for metaphor is related to the human capacity for learning rules of communication through speech using grammar and tone. The use of metaphor also involves the capacity for imagination and the kind of playing with images and words that builds social relationships.

The capacity for language as a social tool evolved as part of our heritage as group animals. In the 1980s and 1990s, evolutionary psychologist Robin Dunbar demonstrated a statistical relationship between the development of language and both social group size and the volume of the prefrontal cortex. Subsequent research into the development of social communication emphasises the capacity to

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articulate emotions to others, and this entails linguistic skills and awareness of lexical rules.

Children's security of attachment to their carers has an influence on the emergence of mentalising skills – the capacity to imagine one's own mind and the mind of others. Such mentalising skills are likely to influence the development of language and other social and cognitive skills that may be mediated by carer sensitivity and attachment security (see Deneault 2023 for a careful review of this issue). Children with secure attachments to their carers tend to have greater autobiographical competence and, in particular, to be able to describe painful feelings like loss and sadness (Holmes 2003). In contrast, children who experience maltreatment of any sort tend to have a reduced emotional lexicon, particularly for painful emotions (Beeghly 1994), though there is considerable individual variation.

Development of the capacity to use metaphor supports the communication of personal experiences to others and the building of trust that enables people to belong to social groups. People who struggle with metaphorical language may suffer from various kinds of psychological distress, but might find it hard to talk at all, or perhaps occupy the narrative space with seemingly tangential or confusing language (Cassidy 2012). This in turn can lead to miscommunication, social confusion and serious misunderstandings of their perspective or views. The relevance for us as clinicians is that patients with significant inner distress may utilise metaphors in ways that are not necessarily immediately accessible to us.

Furthermore, our own personal or medical language may sound off-key to some patients or be taken concretely. As the vignettes illustrate, it may be useful to be prepared to meet patients halfway – to try out entering their language and metaphors to see if this may open up lines of communication.

Conclusions

As we hope these vignettes illustrate, a patient's metaphors may pass by quickly, like blurred trees seen from the window of a train. We suggest that it may be helpful to try to attend to some of these as they click into view – perhaps particularly in consultations where we feel that something important is not quite being articulated. If we do this, we then need to be prepared to see where the metaphor takes us, and to observe whether this approach allows the patient in a bit more.

We acknowledge that our background is in psychotherapy and that these examples come from therapeutic work. Nevertheless, we think that this kind of listening and responding has applications in general clinical encounters, although probably more with patients who clinicians can get to know over a series of meetings. Indeed, attending to the language a patient uses and their emotional tone has been found to facilitate a therapeutic process across a range of settings (Blagys 2000).

Tuning into a patient's metaphors may not, of course, prove useful in all cases. It may be harder if the patient and clinician lack a shared first language. We would also advise against pursuing metaphors when rapport is very low, or where our own or the patient's affect is too high, as these conditions may carry a risk of furthering misunderstanding rather than building understanding. Developing skills and confidence in this aspect of the doctor–patient relationship can be understood as part of clinical training in the dynamics of the 'inner consultation'. This may be variably covered during psychiatric training, and can be cultivated through reflective spaces such as Balint groups.

To conclude, patients have different ways to get through to their clinicians. We should therefore try not to be afraid if a patient seems to go off at a tangent – it may be happening for a purpose. It may prove useful to the consultation if we can pick up on our patient's language and metaphors and reflect this back to them with curiosity.

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Author contributions

Both authors jointly conceived, drafted and revised the article, gave approval for publication and agreed to be accountable for all aspects of the work.

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